CHANGE IN STATUS OF MEDICAID HOSPICE PATIENT

State Form 48732 (4-98) / OMPP 0010

The information contained on this completed form is **CONFIDENTIAL** according to 405 IAC 1-16, 5-2-10.1, 5-2-10.2, 5-5-1, and 5-34.

A. RECIPIENT INFORMATION	
Name of recipient (*last, first, middle initial*)	Recipient's Medicaid number

B. PROVIDER INFORMATION	
Name of Hospice Provider	Hospice Medicaid Provider number
Signature of Hospice Provider	Hospice telephone number

C. THE STATUS of the above patient in the care of the above provider has changed as of _____ / _____ / _____ (*date*) for the following reason(s):

☐ Patient has become eligible for Medicare;

☐ Patient has changed his / her normal daily residence (*NOTE: Fill out A, B or C as relevant*):

A. *FROM:* Private Home
Private address (*number and street, apt. number, city, state, ZIP code*)
TO: Institutional Care Setting
Name of institution
Address (*number and street, city, state ZIP code*)
Medicaid Provider number

B. *FROM:* Institutional Care Setting
Name of institution
Address (*number and street, city, state ZIP code*)
Medicaid Provider number
TO: Private Home
Private address (*number and street, apt. number, city, state, ZIP code*)

C. *FROM:* OLD Institutional Care Setting
Name of institution
Address (*number and street, city, state ZIP code*)
Medicaid Provider number
TO: NEW Institutional Care Setting
Name of institution
Address (*number and street, city, state ZIP code*)
Medicaid Provider number